beginning on the first day of the first open enrollment period that begins on or after September 23, 2012; and

(ii) For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), this section applies beginning on the first day of the first plan year that begins on or after September 23, 2012.

(2) For disclosures with respect to plans, and to individuals and dependents in the individual market, this section is applicable to health insurance issuers beginning September 23, 2012.

[77 FR 8702, Feb. 14, 2012]

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

Subpart A—General Provisions

Sec.

Subpart B—Requirements Relating to Access and Renewability of Coverage

Subpart C—Requirements Related to Benefits

Subpart D—Preemption; Excepted Benefits

Subpart E—Grants to States for Operation of Qualified High Risk Pools

AUTHORITY: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

SOURCE: 62 FR 16995, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth and protects all individuals and family members who have, or seek, individual health insurance coverage from discrimination based on genetic information.

[79 FR 30340, May 27, 2014]

§ 148.102 Scope, applicability, and effective dates.

(a) *Scope and applicability.* (1) Individual health insurance coverage includes all health insurance coverage (as defined in §144.103 of this subchapter) that is neither health insurance coverage sold in connection with an employment-related group health plan, nor short-term, limited-duration coverage as defined in §144.103 of this subchapter.

(2) The requirements that pertain to guaranteed renewability for all individuals, to protections for mothers and newborns with respect to hospital stays in connection with childbirth, and to protections against discrimination based on genetic information apply to all issuers of individual health insurance coverage in the State.

(b) *Applicability date.* Except as provided in §148.124 (certificate of creditable coverage), §148.170 (standards relating to benefits for mothers and newborns), and §148.180 (prohibition of health discrimination based on genetic

information), the requirements of this part apply to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997.

[79 FR 30340, May 27, 2014]

Subpart B—Requirements Relating to Access and Renewability of Coverage

§ 148.120 Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

The rules for guaranteeing the availability of individual health insurance coverage to certain eligible individuals with prior group coverage have been superseded by the requirements of § 147.104 of this subchapter, which set forth Federal requirements for guaranteed availability of coverage in the group and individual markets.

[79 FR 30340, May 27, 2014]

§ 148.122 Guaranteed renewability of individual health insurance coverage.

(a) *Applicability*. This section applies to non-grandfathered and grandfathered health plans (within the meaning of § 147.140 of this subchapter) that are individual health insurance coverage. *See* also § 147.106 of this subchapter for requirements relating to guaranteed renewability of coverage with respect to non-grandfathered health plans.

(b) *General rules*. (1) Except as provided in paragraph (c) of this section, an issuer must renew or continue in force the coverage at the option of the individual.

(2) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market.

(c) *Exceptions to renewing coverage*. An issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) *Nonpayment of premiums*. The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) *Fraud*. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) *Termination of product*. The issuer is ceasing to offer coverage in the market in accordance with paragraph (d) or (e) of this section and applicable State law.

(4) *Movement outside the service area*. For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(5) *Association membership ceases*. For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) *Discontinuing a particular type of coverage*. An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:

(1) Provides notice in writing, in a form and manner specified by the Secretary, to each individual provided coverage of that type of health insurance at least 90 calendar days before the date the coverage will be discontinued.

(2) Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(e) *Discontinuing all coverage*. An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.